City of Milwaukee
Department of Employee Relations
Employee Benefits Division

HOW TO COMPLETE THE HEALTH PLAN ENROLLMENT APPLICATION

GENERAL INSTRUCTIONS

Read this entire section

1) **Write the name of the Health Plan you have selected in Box 1 of Section A of the Health Plan Enrollment Form.** All Active employees **must** include their Employee Identification Number (Employee ID #) on the health plan enrollment application. If you fail to include this information in Box 2, the health plan enrollment application will be returned to you.
2) Complete all sections of the Health Plan Enrollment Form as they apply to you. In Section B, list each eligible dependent, including their Social Security Number and their relationship to you (the subscriber). Please mark the appropriate box. **Social Security numbers for each dependent are required.** Failure to provide the complete information where it is required will cause delays in setting up your membership as well as delays in the issuance of Medical ID cards.
3) **ACTIVE EMPLOYEES**: Return your completed application to the Department of Employee Relations, CH 706 within the designated Open Enrollment period. HACM/RACM, WCD & MECD employees return your completed application to your departmental payroll personnel. Late applications will not be accepted for any plan changes. See the Open Enrollment booklet for more information on the Open Enrollment period. **DO NOT** mail your application to the Health Plan.
4) **RETIREES, DISABILITY RETIREES, and SURVIVING SPOUSE ENROLLEES**: Mail your completed application to **Employes' Retirement System, Heartland Funds Building, 789 N. Water Street, Suite 300, Milwaukee, WI 53202**. **DO NOT** mail your application to the Health Plan.
5) A Domestic Partnership registration must be completed before enrolling a Domestic Partner for Health and/or Dental Insurance.

SPECIFIC INSTRUCTIONS

Read the instructions for the HEALTH PLAN of your choice.

AVAILABLE HEALTH PLAN CHOICES

UNITEDHEALTHCARE (UHC) CHOICE PLAN

SECTION A Write **"UnitedHealthcare (UHC) Choice Plan"** in BOX 1. Without exception, all Active employees must complete BOX 2 by entering the Employee Identification Number (Employee ID #) on the health plan enrollment application. This is required of all Active employees.

SECTION B Please list each eligible dependent and include the Date of Birth, the Social Security Number and their relationship to you.

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BASIC HEALTH PLAN - (Anthem Blue Cross Blue Shield CMS)

SECTION A Write **"Basic Plan"** in BOX 1. Without exception, all Active employees must complete Box 2 by entering your Employee Identification Number (Employee ID #) on the health plan enrollment application. This is required of all Active employees.

BASIC PLAN TIER 1 - (Anthem Blue Cross Blue Shield CMS)

SECTION A Write **"Tier 1"** in BOX 1. Complete BOX 2 as indicated above.

For any Basic Plan Choice above:

SECTION B **For each eligible dependent, list each eligible dependent and include the Date of Birth, the Social Security Number and their relationship to you**.

(The Basic Plan Tier 1 plan is only available to General City Active Management, Active Sworn Fire Management, Active Sworn Police Management employees, Local 494 (Electrical), MBCTC, HACM/RACM, WCD & MEDC employees and Retired Management employees who retired after 01/01/2004.)

Complete all of the appropriate areas of Sections A, B, C, D, and E of the application for all of the health plan selections.

ALL ENROLLMENT FORMS MUST BE SIGNED AND DATED BY THE EMPLOYEE,
THE COBRA ENROLLEE OR THE RETIREE.

EBA-11

HEALTH ENROLLMENT FORM

CITY OF MILWAUKEE

DER/EMPLOYEE BENEFITS DIVISION

Please Type/Print Firmly - Complete All Parts Of Form – Sign & Date form

Read Attached Instructions Carefully

Section A	Box 1 – Health Plan Selection	Box 2 – Employee ID #	DESIRED COVERAGE Single ☐ Family ☐	SOCIAL SECURITY NUMBER

SUBSCRIBER (LAST NAME)	(FIRST NAME)	(M.I.)	(HOME ADDRESS)	(CITY)	(STATE)	(ZIP CODE)

JOB TITLE	CITY START DATE	RETURN TO WORK DATE	MARITAL STATUS	GENDER	BIRTH DATE	HOME TELEPHONE NUMBER	EMAIL ADDRESS
			SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐	MALE ☐ FEMALE ☐	/ /		

Section B – Dependent Enrollment Information

Complete For All Eligible Family Members For Whom You Are Requesting Coverage. Domestic Partner requires pre-registration with the City Clerk's Office.

(LAST NAME)	(FIRST NAME)	(M.I.)	GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER	Relationship
SPOUSE						
DOMESTIC PARTNER						
DEPENDENT						
DEPENDENT						
DEPENDENT						
DEPENDENT						

Section C – Indicate Purpose For Submitting This Enrollment Application by checking the appropriate box. (In the event of marriage or divorce, please provide name change information)

☐ **INITIAL ENROLLMENT** ☐ **OPEN ENROLLMENT** ☐ **RETURN TO WORK** ☐ **ADD DEPENDENT** ☐ **DELETE DEPENDENT (Name):**

☐ **MARRIAGE (**Provide Date)_____ ☐ **DIVORCE** (Provide date)_____ ☐ **SINGLE TO FAMILY** ☐ **FAMILY TO SINGLE**

Maiden Name: _____ ☐ **NAME CHANGE: FROM:**_____ **TO:**_____ ☐ **DEATH DATE:** __/__/__ ☐ **OTHER:**

Section D - EVERY SUBSCRIBER MUST COMPLETE THE FOLLOWING INFORMATION. Write in the information requested and/or check the appropriate box.

1.) Is your spouse employed? ☐ YES ☐ NO If "YES", who is the employer? _____ Tel. # _____

2.) Is anyone named on this application covered under another group health policy? ☐ YES ☐ NO
If "YES", what is the name of the insurance company? _____ Policy Number: _____

3.) Are you and/or any dependent covered by **MEDICARE**? ☐ YES ☐ NO If "YES", supply a copy of each person's **MEDICARE ID CARD**.

4.) Is anyone named in this application now disabled, mentally incompetent or unable to perform normal work or age-related activities? Yes ☐ No ☐ If yes, please indicate name here. _____

5.) Are there any dependents over age 19 who are full-time students? If so, circle first name in **SECTION B** above. (PLANS MAY REQUIRE VERIFICATION OF DEPENDENT ELIGIBILITY.)

Section E - SIGNATURE BLOCK (This application is not valid without a Valid Signature and Date)

☐ I apply for enrollment under the terms and conditions of my employer's Health Plan as administered by the entity stated in BOX 1 and subject to the authorization on the reverse side. I understand that coverage is not in force until the effective date shown on the ID card issued to me. I authorize any payroll/pension deductions that may be necessary to cover the cost of my plan. To the best of my knowledge, all statements and answers in this application are complete and true.

SUBSCRIBER SIGNATURE:_____ **DATE:**_____

NOTICE TO EMPLOYEES AND RETIREES REGARDING THE THIRTY DAY RULE:

Employees and Retirees are responsible for keeping their enrollment status current – notifying the Employee Benefits Division within 30 days of births, adoptions, marriages (including marriage to another City employee), divorces, dependents ceasing to be dependents, former dependents who become eligible dependents again, deaths and Medicare coverage, or active employees may logon to https:\\cmil.mycmsc.com. New employees must complete health and dental application within 30 days of their City start date and employees returning to work must also complete health and dental applications within 30 days of their return-to-work date. (Non-compliance with this Thirty-Day Rule may expose the City and/or you to additional costs.) There will be no exceptions to this rule.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION (BASIC PLAN)

By my signature on the reverse side, I hereby authorize:

(1) Any physician, medical practitioner, hospital, clinic, medically related facility or other institution who provided treatment or service to me, my spouse or my minor child(ren) at any time, or their agent(s) (including billing serve) which are subject to the provisions of Sections 146.81-83 of the Wisconsin Statutes, having medical information which includes but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments, and/or services, test results (excluding the results of a test for the present of an antibody to HIV (AIDS virus antibody test), but including x-rays, summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness including pregnancy and treatment of service, if any, for mental or nervous condition, alcohol abuse or drug abuse including: (a) all programs in which the patient has been enrolled as an alcohol or drug abuse patient; and (b) reports of treatment or service rendered for mental illness, developmental disabilities, alcoholism and drug dependence which are subject to provisions of Section 51.30 of the Wisconsin Statute, and

(2) Any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associate having non-medical information about me, my spouse or my minor child(ren).

To disclose to Anthem Blue Cross/Blue Shield CMS on the reverse side (the Company) or its representative(s) all such information (including photographic copies thereof), as Blue Cross/Blue Shield CMS may request from time to time.

I understand that said information will be used by Anthem Blue Cross/Blue Shield CMS for purposes of payment of claims, third party indemnification, auditing and cost containment measures under the Administrative Services Agreement between Anthem Blue Cross/Blue Shield CMS and the City of Milwaukee. I agree that Anthem Blue Cross/Blue Shield CMS may release said information to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claims(s) or the claim(s) of my spouse or minor child(ren) or as may be otherwise permitted by law or as I may further authorize from time to time.

I further hereby authorize Anthem Blue Cross/Blue Shield CMS to furnish and deliver to the City of Milwaukee or its representative(s), in accordance with said Agreement, said information and also the cost of treatments and/or service, dates of said payment(s), recipients of said payment(s) and such other claims information as provided under said Agreement. I understand that such disclosure to the City of Milwaukee is for purposes of payment of claims, third party indemnification, auditing and cost containment measure under said Agreement.

I understand that I may request and receive a copy of this authorization. I understand that this authorization is revocable upon advance written notice given to Anthem Blue Cross/Blue Shield CMS at its office, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and Anthem Blue Cross/Blue Shield CMS and its directors, officers, employees, and agents shall not be held responsible or liable for such release. I understand that this authorization will remain valid for three years from the date my legal representative or I execute this authorization.

I further understand that a photographic copy of this authorization is as valid as the original.

TERMS AND CONDITIONS (HMO PLANS)

I understand and represent:

1. I have read this document or it has been read to me.
2. The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
3. Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any other rights and requirements.
4. If this application for coverage is accepted, coverage will be effective on the date specified by the Plan on the certificate of coverage/certificate of insurance.
5. Any misrepresentation contained herein relied on by the Plan may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness, and any information that is not personal medical information to include motor vehicle reports and credit reports to give any and all such information to the Plan, its reinsurer or its legal representatives, and its affiliates.

1. The information obtained by use of this authorization may be used by the Plan to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
2. Any information obtained will not be released by the Plan to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as the Plan may further authorize.
3. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
4. A copy of this authorization is available to me or my legal representative upon written request.
5. This authorization shall be valid for two years from the signature date on the front side.
6. I have the right to revoke this authorization at any time:
   a. To revoke this authorization, I must do so in writing and send my written revocation to the Plan's Privacy Office.
   b. The revocation will not apply to information that has already been released in response to this authorization.
   c. The revocation will become effective after it is received by the Plan's Privacy Office.